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ABSTRACT

Data are presented that indicate minorities have been under-represented in the health fields and biosciences. Previous attempts to increase minority involvement have not been satisfactory; hence, alternative approaches should be examined. One alternative is the creation of community-based minority institutions capable of conducting both services and education. This approach is new neither in America nor in other nations. The King/Drew Medical Center is provided as an example. Advantages and problems of such an approach are considered. (RH)

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BETTER HEALTH SCIENCES THROUGH MINORITY PARTICIPATION:

The Case for Community-Based Minority Medical Schools

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The health fields occupy a special place in America. Public opinion polls show the continuing esteem in which we hold physicians (and also bioscientists) (1). The average physician earned $50,000 a year in 1974 (2). Salaries for hospital personnel have been rising relative to those of other wage earners during recent years (3). We as a people spent more than $118 billion dollars on health care, research, and education in 1975 - about 8% of the nation's total product of goods and services (4). In the aggregate, the health enterprise is the nation's third largest employer (4).

What is the record of this powerful establishment on racial justice - our continuing moral and political dilemma (5)? Is the social prestige, money, and employment being harnessed for the advancement of the nation's minorities? The most expensive elements of health care, education and research are located preferentially in affluent neighborhoods and are unavailable to most minority people for health services, employment or community development. Medical schools and their accompanying private and public hospitals (e.g., Veterans Administration, State University, State Psychiatric) have been migrating from the core city and its minority people. As a result, doctors in training do not learn how to provide care to underserved populations, increasing the likelihood of further geographic maldistribution of private physicians. Meanwhile, local metropolitan hospitals in the inner city are closing down (6).

Furthermore, an increasing inequality between minority medical student enrollment and that of others has been evident in recent years. Today, less than 7% of undergraduate medical students are Black, although American Blacks constitute more than 11% of the nations' population (7). There was one white physician for every 538 white people in the United States in 1975, but only one Black physician for every 4100 Black Americans (7). This deprives Black communities of health care leadership, and role models for the young, as well as care-givers.

There is likely to be a further decrease in Black physicians in the future as a result of the recent court decision in Bakke vs The University of California, finding against preferential admissions for minorities to a medical school of the University of California (8).

The reasons usually advanced for the downward trend in these, as well as other programs of distributive social justice, is excessive fiscal cost and lack of data validating program worth, as well as the legal constitutional issue raised by the Bakke case [illegible]. However, the very complexity of the health fields is also a cause of racial inequity (9). I have discussed elsewhere an overall health policy process that would guide programming to meet human and fiscal priorities, establishing program worth and cost efficiency as well as promoting minority participation (10). That process is based on the need for national leadership and policy to resolve current difficulties and problems in health care for all Americans involving advocacy, services, education, research and administration. However, the issue of minority access impinges on each of these global concerns and is in turn influenced by leadership and systematization involving all of them.

For example, the center at which I work in South Los Angeles, maximizes minority participation by virtue of its location, personnel policies, citizen involvement and programming. Yet, it is threatened by the current fiscal crisis affecting municipal governments, because its major teaching facilities are public entities of local government. Also, while the emphasis on outreach programs by established centers in the Federal Health Manpower Act of 1976 is commendable, there is not a commensurate emphasis on the development of community-based medical schools in the legislation. The derivative consequences of current major health legislation have not been adequately examined with regard to the fall-out for minority participation and the correction of ethnic inequities.

In general, policies and programs for minorities can be considered in two categories; (1) those that provide services or fiscal support, and (2) those that

encourage self determination, self help and selfhood. The first approach transfers goods and dollars from the general public to the poor (e.g., food stamps, aid to dependent children) or provides support to care-givers for free services (e.g., Medicaid). The second encourages the development of community institutions controlled by local residents. While there are obvious advantages to methods that foster independence, few examples can be found in the health fields. This might be due in part to the highly technical nature of American medical care and in part to protectionism on the part of the health professions (11).

From the perspective of this community-based medical center, minority participation is a multifaceted issue. The education of minority physicians and other health professionals is one facet. The development of a talent pool of future minority health professionals is another. Participation of all minority people in the defined population of the Center in programs serving their children, their families and themselves is equally obligatory. People can do more to improve their own health than professionals can do for them (12). It will be our contention that this wide spectrum minority participation would improve the nations' health care, health care system, and health sciences. Further, it is best accomplished through the strategy of the community-based medical center.

One of the few exceptions to the prevalent mode of addressing inequities through charity is a new, community-based Medical Center in South Los Angeles which is composed of two sister institutions, the Los Angeles County-Martin Luther King, Jr. General Hospital (and Southeast Health Region) and the Charles R. Drew Postgraduate Medical School. These two allied institutions represent a continuing response by local, State and federal governments to the needs, expectations and requests of a large minority population comprising approximately 60% of the residents of the Southeast Health Region (population comprising approximately 780,000). While that Center is instructive as a model to study for possible national replication, it is as important to analyze its weaknesses as its strengths and successes.

A Community-Based Medical Center

Private citizens, physicians and dentists of the community had been actively seeking both an adequate hospital for services and continuing postgraduate education for health professionals for almost a decade prior to the Watts riots of 1966. Following the riots, the McCone Commission provided the necessary impetus to found a postgraduate medical school and a major public hospital. The hospital and school began patient care activities in 1972. The Los Angeles County Department of Health Services was regionalized into five entities in 1974, giving to the new medical complex the responsibility for a defined population in the Southeast Health Region. Further plans to restructure the services system (emphasizing primary care) have been largely shelved due to the Departments response to the fiscal shortfall that has been felt keenly here (and across the nation) in public hospitals and health systems (13).

The mission of the Drew School is to "conduct medical education and research in the context of service to a defined population so as to train persons to provide care with competence and compassion to this and other underserved populations." The Southeast Health Region operates a series of small clinics and a large comprehensive health care center for ambulatory patients in addition to the King Hospital.

The two institutions are exceptional in several respects. First, the Drew School is the nation's only postgraduate medical school. Second, minority participation involves residents of the community (including the poor) as well as those who have attained professional status - not a unique characteristic qualitatively but quantitatively unusual. Third, there is an unusual degree of Regional County and Drew School policy control of both educational and service programs; again not unique, but clearly contrary to present trends favoring outreach from established medical schools and central bureaucracies. Finally, the Center provides leadership opportunities and managerial experience for minority administrators.

Major accomplishments of the two institutions have been:

Southeast Health Region

- Planned and opened a $30 million hospital, a $7 million comprehensive health center, a $5 million intern and resident building, and other regional facilities.
- Planned and began construction of a $15 million psychiatric facility and clinical research center.
- Recruited an administrative leadership and staff (more than 90% minority composition).
- Secured designation as the first community hospital able to admit and treat private patients in the Los Angeles public hospital system.
- Operates a $[illegible] million annual hospital budget.
- Manages a $[illegible] million annual regional budget.
- Provides employment to 2[illegible]00 hospital workers.
- Provides employment to regional health workers.

Drew School

- Acquired land and temporary administrative offices.
- Recruited a full time faculty of 120 (80% minority professionals).
- Developed approved residency training in most of the major specialties and recognized subspecialties.
- Developed statements of mission and a faculty constitution as well as managerial and fiscal systems.
- Recruited, with the King Hospital, a resident physician staff of 180.
- Sought and obtained recognition as an educational entity of the State of California.
- Constructed bioscience and community medicine research facilities.
- Implemented numerous health services and educational programs in the community.
- Constructed a major Child Development Center.
- Assumed responsibility for a local Headstart Project numbering 13 community sites and a central kitchen.
- Provided 189 physicians; 68% of its resident physician graduates, to private practice locations in the community. (Table 1)
- Gave 255 of its resident graduates to the State of California (92% of total graduates (Table 1).

- Conducts clinical educational programs for 26 undergraduate medical students from other medical schools annually.

- Developed the first Medex (physician assistant) programs in the State of California.

These achievements have resulted from the unique participation by community residents and minority professionals in processes of care, education, and research as well as policy-making. To an extent not seen in most medical teaching centers (public or private), the center is identified as an intrinsic part of the community. This is reflected in the policy process of the school, which proceeds in stepwise fashion. Needs and expectations of the people are identified through personal interaction and measurement. Services are developed in response to these needs and expectations. The skills involved in carrying out service tasks become the curriculum content of medical education programs. Research (medical, social and behavioural) bolsters the advocacy, service and educational components of the system. Finally, management and resource acquisition is derivative from the mandate developed to carry out the first four steps of the policy process.

It can be seen that the community-based medical center can be highly effective in generating new health professionals for underserved areas. Further, most of those who did not choose to remain in the ghetto chose an academic career in the health sciences, another area of under-representation for minorities. The high retention rate of graduates of its resident physician training program in the local community (Table 1) results from several attributes of the King/Drew Center. It shapes the attitudes, skills and knowledge of resident physicians so that they are comfortable about practicing in the area, and confident in their ability to manage its special social circumstances and medical challenges. In addition, graduates prefer to settle in an area adjacent to a center of continuing education and faculty consultation. Finally, many take pride in having helped to shape the destiny of an institution having worthy goals.

Also, as a result of interactions with residents and leaders of the local community, a variety of programs have been developed to foster child health education and development, to train community residents for new occupations (e.g., teachers assistants) and to provide employment for many others. While criticism from community residents is constant, it is also constructive and necessary. This community has been studied for many years and by many different kinds of experts, but without forthcoming prescriptive responses and serious attempts to give to the people their own means to achieve better circumstances of life through health care, educational opportunities or local employment. The community-based center is correcting those deficiencies.

Problems and Pitfalls

There have also been failures in carrying out the community mission. Our academic leadership, which follows the rational process defined above, is in many instances, not a controlling or even a minor influence on program development. The public hospitals and most other elements of the service system are under a County Government. The Board of Supervisors of Los Angeles County sets budgets. In the County Governments, the County Administrative Office is a more powerful influence on the budget than is the Department of Health Services. While most top positions in the Department of Health Services, the Health Regions, the hospitals and the clinics are nominally in the civil service, in reality, appointments are made on political grounds by the County Supervisors. The civil service system itself has its own top level policy makers, who dictate policies to local administrators. Hence, management and resource acquisition reflect a variety of powerful influences over which neither citizens of the community or health professionals have direct control or influence.

It is not always possible to put together programs rationally derived from our mission, due to these extrinsic influences. Here, as elsewhere, empty beds and

clinics become the compulsive force to generate clinical programs rather than real world priorities. Primary care is explicitly defined, but not carried out because of the constraints imposed by hospital or clinic regulations made outside the local center. Of course, intrinsic limitations also play a role in our current imperfections. It is one thing to agree on broad goals, another to carry them out in daily activities with skill, energy and commitment.

Two small federal programs account for almost all of the Center's modest science contributions to teaching, manpower development and the advancement of biomedical knowledge - the Minority Biomedical Science program of the National Institutes of Health, and the Minority Access of Research Careers program of the National Institute of General Medical Sciences. These programs have allowed the school to develop an educational consortium with eight community and junior colleges to provide science instruction to minority students, and to advance the careers of promising young clinical scientists from its own manpower pool. In addition, secondary multiplier effects accrue, since the administrative core and the scientists required for these programs are also available to guide and teach high school students in the region and to strengthen clinical teaching in hospitals and clinics. Also, some members of the science teaching group have been successful in obtaining research grants and contracrs to carry out independent research. Yet, a larger science base is needed in the Center.

Opening the school from the top down (as a postgraduate institution) rather than the bottom up (the usual developmental pattern) has certain advantages. It finesses traditional conflicts between basic scientists and clinical faculty members, for example. However, certain disadvantages result from the absence of basic science departments. It is more difficult to carry out good clinical science in the absence of such cross-cutting disciplines as biochemistry, genetics, and physiology, among others. Clinical scientists are more difficult to recruit. Clinical teaching and

services are weakened when they are not subjected to critical scrutiny and constant reinvigoration by a strong local biomedical science establishment. This will not be corrected until the Drew School develops its own undergraduate medical school and basic science departments.

Clearly, the new medical center is in a position to contribute to medical education through the development of competency-based learning programs that respond to specified priorities of service. This has particular merit when applied to the measured needs and expectations of underserved minorities, who have high mortality and morbidity rates (14) and account for most of the excess deaths and preventible diseases in our service region and in the United States generally compared to other industrialized nations. Further, the Center provides unusual opportunities for academic, as well as community leadership by minority professionals. It would also help to reverse the current downward trend in the proportion of minorities among medical school graduates.

However, there is a strange reluctance on the part of some of our political and administrative leaders to accept the identification of the Drew School or King Hospital as minority institutions. Clearly the State of California needs to educate more minority physicians (Table II). Yet it has been stated here, by State policy makers, and by health policy makers in the federal government, that programs or institutions designated for minorities will fail to compel broad-based interest and support among Americans in the current political and social climate. For that reason, we can expect difficulty in obtaining support and recognition of the proposed extension of our current activities to undergraduate medical education - an essential evolutionary step if we are to maintain high standards of service and education, as well as community responsibility. Further, the American Association of Medical Colleges has recently issued a position paper discouraging the developmentof new affiliated two year clinical medical schools. The Carnegie Commission has published

a study indicating that the nation now educates too many physicians (although it distributes them poorly by specialty and by geographic region). Altogether, these trends are not propitious for the development of any new medical school, especially one designated for broad-based minority participation.

It can be seen that an unusual range of services is likely to occur in the community-based medical center. Services respond to need rather than professional tradition. Hence collective efforts are likely to occur between health professionals, citizens and the members of other professions. These efforts result in part from the explicit identification of the things that people can do for themselvees and their own health, those that can be done by individual health professionals, and those that require teamwork (often negated by considerations of professional status and territoriality) between health centers and other community agencies. In the community-based medical center, the focus is on getting the job done, rather than on professional preconceptions and prejudices. Of course, the actual fact is that at King/Drew, the goals and objectives are together, only one influence on attitudes and behaviour. Newcomers among the professional staff invariably go through a difficult introductory period. When the Center first opened, we set up a series of primary care teams as the nexus of services and postgraduate training in one Department. The system failed because not enough of the faculty were expert in primary care (or committed to it) and because of lack of accountability among the resident physician staff. However, the Center policy does stimulate directed movement and a reorientation of professional practice toward real-world priorities of health care.

Conclusions

Many attempts have been made in recent years to increase minority participation in the health fields and biosciences. Most have taken the form of special programs to increase access to health care or enrollment in professional education programs. Many of these efforts appear to be losing their vitality with a resultant further increase in the inequity of services and of opportunities for technical and professional education.

In view of these incompletely satisfactory results, it seems worthwhile to examine alternative approaches. One alternative is the creation of community-based minority institutions capable of conducting both services and education. This approach is neither new in America or in other nations. However, it is worthwhile examining those unusual instances in which it has been applied to the problems of distributive social justice. In this regard, the King/Drew Medical Center is suitable for analysis.

The King/Drew Medical Centeris unusual in several respects. It is the nation's only postgraduate medical school. It is historically and currently a result of broad-based participation by minority peoples. All citizens of the defined population can interact with the center through its programs of education and service. The leadership of school, hospital and health region is a minority leadership. The majority of faculty, staff, postgraduate trainees and students are themselves derived from the minorities they serve. This new center is located in an underserved region of poor minority people.

Judging from its record to date, a movement toward establishing community-based Medical Centers would make possible minority participation on a broad scale. The results would help in the economic revival of poor communities. New jobs would be created. Preprofessional programs of manpower development would result. A reality

base would be provided for health education and health promotion. Health services would become more accessible. The distribution of health professionals would be improved because of the presence of postgraduate training programs specifically designed for underserved communities, and because of the continuing presence of a major service, education and professional center for private health practitioners. These are some of the many advantages to this approach as revealed in this examination of the accomplishments of the King/Drew Medical Center.

Drawbacks and potential pitfalls are also evident in the brief history of that Center. It is by no means certain that any major center so heavily dependent on funding by a local government is viable. Serious problems are encountered in moving the academic establishment to accept or foster any new medical school, much less a two year affiliated school or a minority school. Without such acceptance or encouragement, it is difficult indeed to launch an enterprise of such complexity as a modern health education center.

There is also the question of the long-term viability of a postgraduate school. It is not feasible to develop or sustain necessary high quality science programs in the absence of basic science departments. Postgraduate training and faculty development are adversely affected by the absence of strong programs in the health sciences. Only a conscious policy of fostering community-based medical centers can give the King/Drew program a destiny. Such a policy would advance minority participation in the health fields. More importantly it would serve all of the nations minority peoples.

The strategy of the community-based medical center is presented as one way to increase minority participation in the health sciences. However, it does something more. It provides a structural arrangement which will strengthen the health sciences. It encourages science programming for the young people of minority communities, increasing the talent pool for the biomedical science and health professions

through education and career guidance. There is also created a natural interface between minority professionals and the target minority communities, enhancing informed advocacy and strengthening the quality of community life.

Table 1

WORK LOCATION OF GRADUATES FROM HEALTH SCIENCES EDUCATION PROGRAMS
CHARLES R. DREW POSTGRADUATE MEDICAL SCHOOL
MARTIN LUTHER KING, JR., GENERAL HOSPITAL
1973-76

PROGRAM CLASSIFICATION	NUMBER OF GRADUATES				RESPONSES		GEOGRAPHICAL WORK DISTRIBUTION		NUMBER OF GRADUATES SERVING IN MEDICALLY UNDERSERVED AREAS				
	73-74	74-75	75-76	Total	Not Reporting	Total Reporting	In-State	Out-of-State	Southeast Health Services Region	In-State*	Out-of State	Total	%
MEDICAL EDUCATION (Residents and Interns)					—								
Anesthesiology	0	0	0	0	0	0	0	0	0	0	0	0	
Community Medicine	0	0	2	2	0	2	2	0	2	0	0	2	
Denistry													
Oral Surgery	0	1	1	2	0	2	2	0	1	1	0	2	
Pedodontics	0	2	1	3	0	3	2	1	1	0	0	1	
General Practice	5	5	3	13	0	13	0	13	8	1	0	9	
Family Medicine	0	0	0	0	0	0	0	0	0	0	0	0	
Medicine	12	23	17	52	3	49	41	8	27	4	7	38	
Obstetrics/Gynecology	0	4	5	9	1	8	8	0	4	2	0	6	
Pathology	0	0	0	0	0	0	0	0	0	0	0	0	
Pediatrics	10	25	4	39	4	35	27	8	14	2	4	20	
Psychiatry	1	1	3	5	3	2	2	0	2	0	0	2	
Radiology	5	4	11	20	1	19	17	2	5	4	0	9	
Surgery	0	2	7	9	3	6	5	1	4	0	1	5	
Sub-Total	33	67	54	154	15	139	106	33	68	14	12	94	61%
HEALTH SCIENCES EDUCATION (Including Allied Health Training)													
Adult Nurse Practitioners	0	0	8	8	1	7	7	0	4	2	0	6	
Master Mental Health Planners	0	24	0	24	2	22	22	0	15	3	0	18	
MEDEX (Physician's Asst.'s)	35	18	29	82	2	80	78	2	36	34	10	80	
Medical Technologists	0	4	5	9	2	7	6	1	5	1	0	6	
Minority Bio-medical	0	1	1	2	1	1	1	0	0	1	0	1	
New Careers	0	0	15	15	0	15	15	0	13	2	0	15	
Nurse Anesthetists	18	5	4	27	8	19	19	0	6	3	1	10	
Trauma Nurse Specialists	0	40	12	52	1	51	50	1	30	5	0	35	
Nuclear Medicine Techs.	4	3	3	10	0	10	9	1	6	1	0	7	
Radiologic Technologists	0	0	12	12	3	9	9	0	6	0	0	6	
Sub-Total	57	95	89	241	20	221	216	5	121	52	11	184	83%
TOTAL	90	162	143	395	35	360	322	38	189	66	23	278	77%
Percentages Under Major Headings	23%	41%	36%	100%	9%	91%	89%	11%	68%	24%	8%	100%	
Total Percentage of Reporting Drew Graduates Serving in Medically Underserved Areas									53%	18%	6%	77%	

*OTHER THAN SOUTHEAST HEALTH SERVICES REGION

Office of the Registrar, Charles R. Drew Postgraduate Medical School
9/76

TABLE 2*

Demographic Characteristics of First-Year Students Selected By Medical Schools in the State of Californa, 1974[2]

Medical Schools	Number of Students	Men	Women	Black American	Mexican-American	Mainland Puerto Rican	American Indian
Public:							
UCD	100	66	34	5	9	0	1
UCI	79	58	21	17	12	1	1
UCLA	147	123	24	6	16	1	2
UCSD	96	75	21	5	4	0	0
UCSF	147	95	52	14	13	1	1
Total	569	417	152	47	54	3	5
Private:							
LLU	154	125	29	9	2	0	1
USC	130	99	31	5	9	0	1
Stanford	94	65	29	11	8	0	1
Total	378	289	89	25	19	0	3
Grand Total (%)	947 (100%)	706 (75%)	241 (25%)	72 (8%)	73 (8%)	3 (0.3%)	8 (0.8%)

* Phase I Report Educational Policy and Curriculum Committee Charles R. Drew Postgraduate Medical School: Chairman, George Locke, M.D.

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